ILHIE **ILLINOIS HEALTH INFORMATION EXCHANGE**

Towards Electronic Data Sharing and Care Integration: The Illinois Behavioral Health Integration Project

Submitted by the Illinois Office of Health Information Technology
of the State of Illinois February 26, 2013

The Illinois Office of Health Information Technology gratefully acknowledges the importance of the C/HS-HIE project to connecting behavioral health providers and consumers to the ILHIE and charting a course for their inclusion in the years to come.

Table of Contents

Attachment

Backdrop for Illinois' CIHS HIE Grant

Illinois built a strong policy foundation to reform its state Medicaid program and address the mental health service needs of its recipients, starting in 2009 and in the run-up to applying for the SAMHSA-HRSA national demonstration project on CIHS-HIE. Among the state policy changes that Illinois secured in the wake of the Affordable Care Act and the American Recovery Act, Illinois authorized the creation of the Illinois Health Information Exchange (ILHIE); it defined insurance coverage parity for individuals with mental health diagnoses, and began the process towards Medicaid reform, addressing care coordination among medical and behavioral health providers and performance fee structures.

Illinois was one of twelve states eligible for the CIHS-HIE program primarily because of its commitment to including the behavioral healthcare community in the planning and development of the ILHIE, which was in its second year of development by the time National Council awarded the grant. The ILHIE's authorizing act, passed in 2010, required the inclusion of behavioral health in both the administration of the exchange and among the stakeholders serving on its Advisory Committee for its statewide health information exchange entity, the Illinois Health Information Exchange (ILHIE). Illinois also enacted historic Medicaid reform legislation in 2010, which specified that services would be provided in a "coordinated care" setting, involving behavioral health care and that health care services could be delivered via electronic health records.

Illinois just awarded its first Medicaid care coordination contracts in 2010 for Seniors and Persons with Disabilities in the suburbs of Chicago. A second RFP for provider-driven care coordination networks across the state was issued in 2012. At the end of 2012, **HFS** selected six provider networks, called Care Coordination Entities. Behavioral health is a central component of these entities.

Illinois Medicaid reform also triggered the transition of individuals out of Institutes of Mental Disease, reflecting a broader State policy shift from institutional to community-based care. And in 2011, Illinois Governor Pat Quinn signed into effect the Mental Health and Addiction Equity Act, requiring health insurance plans, including those for employers with 2-50 employees, to cover mental health and addiction services on par with medical services.

Despite the promising advancements in the policy framework to support care integration, Illinois has struggled with one of the nation's most severe revenue shortfalls since the economic downturn. While the State enacted a two percentage point increase in its personal and corporate income taxes in 2011, it simultaneously has had to reduce spending and roll back its commitments especially in Medicaid, as well as mental health.

Medicaid reduced its patient roles by 1.7 million by lowering the eligibility threshold to 133% of Federal Poverty in anticipation of both the new eligible individuals joining the patient load in 2014 and the health insurance exchange covering all those above 133% starting that year as well. Medicaid also experienced a concomitant budget reduction of $1.6 billion. Some estimate that mental health funding has declined by 30% since 2008.

When Illinois received the funding to participate as one of five states in the national demonstration project for the CIHS-HIE in January 2012, it was embarking on project that would engage with providers and consumers long familiar with very stringent practice areas and silos of care in mental health and substance use services. Illinois remained one of the states with a restrictive mental health confidentiality statute that was broad in scope to the point of governing all mental health record, no matter the origin or location.

This Confidentiality Act specifies that each and every time any mental health information is to be shared with a healthcare provider the patient consent determines the duration for which the information is effective, specified the information, the provider of information and the recipient as well as required a witness. In 2011, an exception to the consent provision of the law was issued to allow for Medicaid funded interagency teams to exchange information, yet the law continued to prohibit real time electronic exchange of mental health data.

A few critical elements would be required to modernize the Act to support health information exchange. In particular, the Act would need to acknowledge the existence of the State HIE as well as the real time nature of exchange, that information would be transmitted not just point to point, but also shared in an interagency setting once Health Homes are underway.

The existing mental health confidentiality law indicated a preference to restrict real time data sharing among behavioral health care professionals and their medical colleagues. The practice culture supports long and strongly held sentiments regarding protecting consumers from stigma and discrimination by relying on service systems that are largely mutually exclusive of medical services. The absence of EHR incentive payments under the Recovery Act corroborated national data that pointed to reduced adoption rates for behavioral health providers investing in HIT or EHR systems.

In preparing its project plan for the Behavioral Health Integration Project (BHIP), Illinois endeavored to ensure that at the end of the project, behavioral health providers were ready to adopt EHR systems, were able to exchange health information electronically and that the ILHIE understood what policy and programs would be necessary in order host behavioral health providers on the system and foster real time electronic data sharing of behavioral health data.

BHIP Program Design: Illinois designs BHIP to educate and engage stakeholders in what Illinois's data sharing policy framework should look like.

When the National Council awarded Illinois a grant at the beginning of 2012 under the CIHS-HIE funding program to promote and establish electronic exchange of behavioral health data in real time with medical providers, Illinois was the only large state to be selected to participate. At that point, Illinois' efforts to launch the ILHIE were two years in the making and it had just launched its first service, ILHIE Direct, a point-to-point secured and encrypted messaging service. While Illinois Medicaid's first care coordination effort had just launched. there were not any widely known cases of the electronic exchange of behavioral health and medical records in the state. One of the many benefits of being awarded the CIHS grant and participating in the national demonstration of behavioral health data sharing at this point in the ILHIE's development is that the behavioral health community would be engaged at a critical point in the launch and evolution of the ILHIE.

Political complexity is also a hallmark of a large state. Despite the austere fiscal environment in Illinois, the behavioral health stakeholders are broad and robust. In the application for the grant, Illinois included twenty-five letters of endorsement. issued from state agency colleagues and nonprofit stakeholders, representing both mental health and substance use treatment professionals and organizations. Three trade statewide associations (the Illinois Alcoholism and Drug Dependence Association, Illinois Association of Rehabilitation Facilities and Community Behavioral Health Association) in addition to the state agency designated team members and Illinois' two Regional Extension Centers formed part of the steering committee for the project. With all the right people at the table, the team targeted mental health

and substance use treatment providers to engage in BHIP, as all the Phase 1 services of the ILHIE would involve providers. At that point in time, we still did not know whether behavioral health providers, let

alone consumers, were aware of the ILHIE or in any way interested in or engaged in HIT efforts. Once we had an understanding of how providers viewed the ILHIE, we knew that we would have an entry point to the discussion with consumers.

Work on BHIP kicked off with weekly steering committee calls, the development of project planning documentation (logic model and work plan), and preparations for the first Statewide Meeting to launch the project in late March. Several timely initiatives coincided with the launch of BHIP in Illinois: i) the culmination of legal research addressing confidentiality for individuals with sensitive patient health information (including mental health and substance abuse) lead by the General Counsel at OHIT; the convening of the Data Security and Privacy Committee by the ILHIE Authority Board to determine and recommend the overarching consent management structure for the ILHIE; and, iii) the launch of a behavioral health provider survey to determine HIT capacity in the behavioral healthcare provider community, implemented by the Behavioral Health Work Group of the Advisory Committee to the ILHIE.

The first Statewide meeting, scheduled for March 29[1]h launched the project and established the tone of the dialogue to be held with stakeholders throughout the project. Over three hundred individuals attended the meeting in one of three venues (Naperville, Springfield or on the web) to ensure that the maximum number of providers could participate. Invitations were sent out through the newly created BHIP list serve, which includes most licensed and funded behavioral health providers in Illinois. We also sent out invitations through several outlets in state government and through the participating trade associations.

The meeting sought to introduce the provider community to BHIP and to begin a dialogue with them on how to shape the relationship between behavioral health providers and the ILHIE. An overview of BHIP was given to attendees. OHIT, DHS and HFS, along with the leadership of the trade associations, opened the meeting to convey the importance of BHIP to the future of health care in Illinois. Lead attorneys heading up the Work Groups on Behavioral Heath and Substance Use of the ILHIE's Legal Task Force provided an overview of why Illinois law would have to be modernized to accommodate the role of the ILHIE and a real time data sharing involving mental health data. Highlights of the Behavioral Health Organization HIT Survey were shared with the attendees. The CIHS grant administrator, Mike Lardiere, presented on efforts underway national to integrate behavioral health care.

The Statewide meeting offered the forum to host the first convening of the Data Security and Privacy Committee of the ILHIE Authority Board, whose task was to determine and recommend the consent management structure for ILHIE itself. As the project team and the steering committee prepared for the meeting, some time was spent to identify behavioral health providers and consumers to testify at DSPC's inaugural hearing. Several providers and one consumer advocacy group representing individuals with mental health disorders presented testimony.

The Statewide Meeting, as all of the initiatives of BHIP, gave us the opportunity to test our assumptions and better gauge next steps. During the Data Security and Privacy Committee hearing, we learned that MetroChicago HIE, a regional health information exchange organization comprised of hospitals in the metropolitan Chicago area, made the determination that mental health data could not be administered via the HIE, for the HIE, structured as a data repository. was not able to adhere to requirements under current mental health confidentiality law. The testimony from a consumer of mental health services indicated that he would want for his physicians to have access to his mental health records so he could receive better health care. The Behavioral Health Organization Health Information Technology survey, which had a 18% response, revealed that nearly 40% of behavioral health providers were using electronic health records in at least some of their care environments. And of the 18% of providers in attendance that

responded to the survey for attendees, they indicated that 60% of them have adopted electronic health records.

Walking out of the first statewide meeting, we realized that the landscape of HIT for behavioral health providers was much more complex and much less homogeneous than we anticipated. We had tapped into a cohort of providers that were ahead of their colleagues in adopting electronic health records. This raised many questions as to their position on confidentiality and how they were viewing the imminent change and transition to medical health homes and care coordination and integration initiatives on the horizon. At that point, we determined that we would test further to see what might exist in terms of positions and perceptions regarding confidentiality and care coordination.

The Summits: Provider Focus Groups

After the first Statewide Meeting, the project turned to focus on developing the tool-kit, involving a consent form and provider protocols on implementing the consent form, as well as designing the capacity study to better define the universe of behavioral health providers. We aimed to understand which cohort of providers would be subject to care integration and Medicaid reform in Illinois. As this work took root, we realized that we would need a much clearer understanding of where providers stood on confidentiality and care coordination.

While the CIHS-HIE grant required that we undertake some form of provider and consumer engagement, we determined it would be best to host focus groups as they would allow us to have a better understanding of the meaning behind service concepts of care coordination and confidentiality, rather than measure the frequency of positions in relation to those issues. We augmented the focus groups with a survey, which gave us more information about the attending organizations in the room.

By mid-April we had circulated a design concept to the project Steering Committee for provider engagement, involving four, large format focus groups to take place across the state for the purpose of aggregating provider support for and positions on the framework to facilitate the integration of BHOs into the HIE, and educate providers on existing latitude under current state law. By the time we confirmed the final schedule for the focus groups, we had to add a second focus group in Chicago to accommodate the demand for participation.

Approximately 133 unduplicated organizations attended and there were164 attendees. One-hundred and twenty individuals submitted responses to the survey conducted during the focus groups. Focus groups were held in Rockford, Chicago, Springfield and Southern Illinois (Carterville, just outside of Carbondale). Every Thursday and the last Tuesday of June 2012 were scheduled with a summit. Over twenty facilitators were recruited to participate and were paid a small stipend to spend the day at each Summit and facilitate small group discussions which occurred at the beginning of the day.

Summit Format

The dialogue in each Summit was structured in exactly the same way. The opening presentation lasted approximately 30 minutes and explained both what the ILHIE is and what it does, including a short discussion on ILHIE Direct as the first service of the ILHIE. Also, an overview of BHIP was provided. Next, an attorney presented on the legal barriers of exchange and integration in the existing mental health confidentiality law. After a Q&A session on the overview, the audience divided into small group

discussions of approximately five to seven or seven to ten individuals, depending on the size of the audience and the number of facilitators present.

Facilitators and participants had approximately two hours to define the complexity of the patient group that they work with according to the Four Quadrant model; determine how their services would be categorized according to that model; identify what forms of care coordination currently exist and what forms should exist; identify the type of health information they need from the HIE to run their services and the type they typically give to other providers in their current trading networks. Finally, based on this initial work, participants would identify the consent model that they felt was appropriate to a care coordination environment.

The full group would then break for lunch. After lunch, all small groups would come back together as an audience and each group would report on their findings, which would be recorded by the lead Summit facilitator on newsprint paper for the room to see. Once all results were listed and categorized, the lead facilitator would narrate main trends and microtrends present in the data to illustrate the spectrum of opinions on what medical data is necessary in order to provide and what the consent model should look like.

The first Summit, held in Rockford at a substance use treatment facility, became the de facto beta test of the process. Since there were only 18 attendees compared to the average of 30 in the other summits, we learned that while most elements of the facilitation worked and produced clear results, the one element that was restructured was in mapping the care coordination environment. Instead of developing a flowchart in the small group, we introduced the Four Quadrant model and used that as a way to categorize patient complexity and service provision in the communities where we conducted summits.

Summit Results

Eighty-four percent of participants at the Summits represented mental health and substance use treatment providers. Close to thirty percent served in the C-suite and about forty percent were clinical or administrative directors. About 65% of attendees were licensed behavioral health practitioners. Over ninety percent of organizations represented had or were planning on implementing an EHR system, a finding which reinforces the notion that these behavioral health providers are advanced in HIT.

Through both the qualitative data collected during the focus groups and the quantitative data of the surveys. we learned that the attendees placed a high priority on medical information for their consumers and their most frequent trading partner was typically a medical provider. The top five pieces of health information that they sought included: medication list, medical history, diagnosis, discharge summary and allergies. However, providers indicated that they valued less sharing information in care coordination environment or in encouraging patients to share information with other specialists involved in their treatment.

The high interest in acquiring medical health information and the lower emphasis on coordinating data for treatment purposes other than behavioral health points directly to the key paradox in the focus group findings: essentially the need for health information and the unwillingness to share it. In light of the five top data elements that were identified, it would be unlikely for any one provider to generate that data unless she were a primary care physician. We understand this paradox to point to both the increasing ability of behavioral health providers to incorporate health data in their practice environments through electronic health record systems, and the acknowledgement of long-standing privacy and confidentiality practices and culture seeking to staunch stigma and discrimination, frequently viewed in the medical

arena, present in the practice environment.

Results also revealed the prevalence of faxing indicates the heavy reliance on paper-based processes. At the time of the summits, fax remained the most prevalent mode of transmitting information, next to sending information U.S mail, and only a small fraction still used the phone to share information. Even though nearly all providers at the summits had or were in the process of implementing EHR systems, they still administered treatment and care on paper-based systems.

The portion of the summits that focused on consent management revealed a broad spectrum of opinions. Since the first summit was held at a substance use treatment center, many of the attendees preferred more stringent consent policy and functions. In fact, during the full group discussion at the end of the summit, one provider suggested that the most efficient way to manage consent would be to adapt all consent forms to the most stringent consent policy; here he referenced 42 CFR Part 2. (Since then it has been widely recognized that the Illinois Mental Health Confidentiality Act is more stringent since it requires a witness for each consent.)

Even in this first summit, hosted by a substance use treatment center, positions varied on consent. During the group feedback session, several providers had made the point that granular consent would deliver the best protection against stigma and discrimination. This participant specified that it would be best for individuals in treatment for addictions to have a card, much like an ATM card, encoded with their consent preferences. In response, a provider raised a very compelling question: Would we address stigma and discrimination if there were more opportunity to coordinate care with medical providers?

If we anticipated that the next four summits would provide a similar debate, we would be wrong. In fact the next four summits illustrate how varied positions were on consent and revealed what were the deep seated issues regarding stigma and discrimination, especially in relation to individuals with addiction. Three broad positions on consent emerged along a spectrum: the first, consistent with very granular and protective policies, sought to give patients full responsibilities over each and every data element of a health record; the second sought to give patients rights over the record as a whole with annual review and approval; and the third sought to relax consent with HIPAA.

By the fifth summit, participants engaged in a wide ranging discussion on stigma and discrimination, focusing on what could adversely affect an individual working with addiction or a mental health diagnosis. This discussion helped to illustrate the tangible liabilities and real world vulnerabilities of individual health information leaking into a civil or criminal law proceeding, or worse yet exposure to the criminal justice system.

The qualitative and quantitative data gleaned from the Summits bore out several clear conclusions regarding providers:

- Mental health and substance use providers know and are committed to health information technology and the adoption of EHR systems.
- EHR usage was prevalent among participating providers (over 90%).
- All providers value health data for their services in order to provide optimal care to their consumers.
- Consent process should be embedded in treatment, and providers should educate consumer on privacy and security of health data.
- Providers have little exposure to all three laws (e.g. HIPAA, 42CFR Part2, IMHDDCA) governing consent and privacy protections, and indicated interest in more education.
- Providers are anticipating the roll out of behavioral health data integration.

- Provider decision-makers are listening to this discussion and are comfortable in the policy arena.
- Data driven services are at odds with restrictions, especially in light of co-morbidity rates.
- For substance use providers, concern centers on protecting against stigma and discrimination and whether consumer data will be accessed for civil or criminal law proceedings.
- Providers are concerned about funding cuts, managed care, and changes to prevailing practice culture (especially SA).

Data Security and Privacy Committee

We presented findings from the Summits at the DSPC Committee Hearing on July 27, 2012. The ILHIE Authority board had convened the DSPC to recommend the ILHIE consent management process, in addition to recommending proposals on existing confidentiality statutes protecting sensitive patient health information. The DSPC conducted four hearings and had [XX#] of individuals and organizations testify.

One of the three trade associations affiliated with BHIP provided testimony. Several other organizations and individuals also provided testimony in relation to behavioral health. On the whole, some organizations affiliated with BHIP still found it premature for their organizations as they had not yet normalized the information regarding how the HIE functions and how consent processes generally work for HIEs.

The DSPC committee concluded that an opt-out provision would be best to allow for an adequate level of data to inform clinical processes and optimize the technology that is currently available. As part of the recommendation on opt-out there is a commitment to upgrade the technology as it evolves and to modify and operationalize statewide consent policy accordingly. Further, the DSPC issued the framework for the proposal to modernize the Illinois Mental Health Confidentiality Act, drawing on the recommendations from the Work Groups of the ILHIE Legal Task Force and the provider Summits, which among other things underscored how highly providers valued clinical data for the treatment of their patients and consumers.

On September 18th, the DSPC recommended to the ILHIE Authority Board that Illinois adopt an opt-out consent management process for all patients. In order to support that, this original recommendation advised Illinois to harmonize its mental health consent policy to HIPAA. Later on, during extensive negotiations with stakeholders that it would be best to uphold patient choice and ensure that mental health consumers retained opt-out as well.

An initial draft of the legislative proposal was ready as this recommendation was presented and upheld by the Board. It is important to note that the basic proposal to modernize the Act accepted and supported by the Board in September was further refined to reflect a great deal of stakeholder input.

Between July and the end of the year, BHIP spent considerable time sharing the findings of the Summits with stakeholders and organizations that would listen. The Provider Summit findings became the basis to educate providers and other stakeholders on the HIE, the consent management system and the role of clinical data to behavioral health services. These findings also served as the foundation to the discussion on modernizing the Mental Health Confidentiality Act. This is a list of meetings held during this period and even afterwards as the process to modernize the Act took on its own life:

- July 25th: Webinar on BHIP Findings
- July 27th: Presentation to the DSPC
- August meetings: IARF BH committee, exec committee, Stakeholder meeting

- September meetings: Mental Health Summit, IADDA conference, DHS - SSAC
- October presentations: IARF conference; Mental Health Committee of the ISBA
- November: 2nd BHIP Statewide Meeting
- December: CBHA Annual Conference

Initially, we intended to introduce the proposal during the Illinois legislature's veto session, which was scheduled much later than expected, due to the national election, and occurring the last week of November and first week of December. Even if veto session did not work out we would continue to look for opportunities when the legislature convened in January for a six day lame duck session prior to the 98th General Assembly convening. In light of Illinois's fiscal predicament, the first available moment at which we found an opportunity to introduce the proposal turned out to be in January at the convening of the new General Assembly.

Modernizing the Illinois Mental Health Confidentiality Act

By the time that we submitted the proposal to the legislature for drafting and filing in the third week of January 2013, it was a consensus bill, largely reflecting substantive feedback from the Illinois State Bar Association's Mental Health Committee. Working closely with this Committee, the proposal offers both providers and patients a choice in how they want to share health information. Specifically, the Mental Health Committee sought to give providers affiliated with the ILHIE full options in relation to electronic health information exchange. Whereas providers that continue to utilize paper-based processes and that are not affiliated with the ILHIE would continue to administer consent according to existing law, which entails sending granular information via fax or US Mail, or should the patient so indicate, not sending information at all. Hence consumers being treated by providers affiliated with the ILHIE, under the new proposal, will have the option to have health information transmitted electronically. These patients will have also the option to decline electronic transmission and send granular information by fax or US Mail, or completely decline to exchange any information.

Consumer Focus Groups

Now that there was clarity on how the provider community viewed care coordination and consent management, we were in a position to convene consumer focus groups to have a better understanding of how mental health and substance use treatment consumers viewed sharing their sensitive patient information with physicians and other specialists.

In October and November, we organized four consumer focus groups. These focus groups furnished an opportunity to educate consumers on the ILHIE, the emerging consent framework and to solicit feedback. We structured the patient groups according to the recommendation of the Behavioral Work Group of the Advisory Committee of the ILHIE, where one group of consumers would be strictly those receiving mental health services, another strictly substance use and a third would include a mixture of the two.

Over forty consumers participated in the focus groups, which were convened in three distinct geographies of the state, Chicago, suburban Chicago and central Illinois. DHS Division of Mental Health convened a focus group during a peer-to-peer call with mental health consumers. As with the provider summits, any assumptions that we had in approaching the consumer focus groups dissolved as we carried out each of the three discussions.

First, what was noticeably absent from the discussions was any collective outright objection to the concept of the exchanging sensitive health data electronically. We did encounter one participant, who self-disclosed as paranoid and who stated that he did not have any interest in having his patient health information shared with the ILHIE. Other than that individual, participants were largely focused on which providers they trust. There was general agreement that they trust providers to whom they have been referred by their existing behavioral health practitioner.

Second, most consumers stated that they would want their physicians to have information regarding their medications and diagnoses if that would improve their health and prevent any harmful experience. Some participants went as far to say that as long as they had access to their rights under the consent management system. and that information would not be used in a civil or criminal proceeding, they were very comfortable with sensitive health information being sent electronically.

Across all four focus groups, we found that, despite the fact that we had sought to hold the sessions in specific program environments. participants in all three live groups disclosed that they are dual diagnosis. coping with a mental health disorder and an addiction. While we did not institute a survey to participants and do not have a quantitative profile of participants, it was surprising the degree to which most individuals in all three live focus groups identified with dual-diagnosis.

The focus groups involving only substance use treatment consumers illustrate how one group thought about electronic exchange. As with the other two sessions, this one spent the first thirty minutes describing the ILHIE, its functions and obligations and the consent management system. Unlike the other sessions, participants spent close to another twenty minutes simply asking questions about how physicians and psychiatrists would be able to track prescriptions. While participants did not outright state their concerns, their curiosity largely focused on access to prescription medication and the degree that the ILHIE prevents the writing of multiple scripts for the same purpose.

Also during this focus group, two participants disclosed that they work in healthcare, one as a medical records assistant and the other at doctor's call-in center. The medical records assistant discussed how ineffectual the fax was in conveying private information. Even though part of her responsibilities was to deliver information that arrived at a dedicated fax, she said that it was very difficult to ensure that the records are timely, complete and delivered to the right person. The call-in center operator talked about how patients are unaware of confidentiality protections and frequently leave very sensitive information in a message.

On the whole the consumer focus groups showed us that this group of consumers, some of whom were formerly homeless and some of whom were affluent, wanted access to healthcare. In each focus group, there was always a few participants that established that they wanted to prevent any health information being used against them in a civil or criminal proceeding. In addition, they wanted to be fully informed of how and what information would be passed from one provider to the next. During this portion of the discussion, one or two consumers acknowledged that they did not have a good understanding of confidentiality under current law-what they are signing when they arrive for treatment and what their recourse is should a breach occur.

Demonstration Projects

In July, we released the RFP for demonstration projects. We had enough data from the Summits and the BHO HIT survey to know that there were a sufficient number of providers using electronic records and that fax was the most frequent mode of transmission among providers. In designing the RFP, we were targeting mental health and substance use treatment providers intrepid enough to attempt the electronic exchange of information, utilizing ILHIE Direct, a secured, encrypted email system.

At that point, ILHIE hosted approximately several hundred registered users with few using Direct in everyday settings. One promising use case that did emerge early in the year and involved a behavioral health provider, Ada S. McKinley, which employed direct with an inpatient psychiatric hospital, Hartgrove, to begin to exchange discharge papers so that as McKinley conducts intake on new patients they have the discharge summary available. While the emergence of the McKinley use case was not directly linked to BHIP, Mckinley did learn of ILHIE Direct at the first Statewide meeting held on March 29[1]h and subsequently participated in the provider focus groups.

The McKinley- Hartgrove use case showed us that a provider with an EHR system (McKinley) and paper-based (Hartgrove) could utilize ILHIE Direct to the advantage of each party. By introducing ILHIE Direct in the discharge process meant that critical information in the discharge summary was available as the consumer walked in the door at McKinley. creating optimal circumstances for a warm hand-off to outpatient care.

When we released the Request for Letters of Intent in July, we did not have any idea how many providers would apply for the program. Projects would be funded at the $50,000 level and there would be two to three awardees. We received twenty-three applicants for the Letter Of Intent, which were five-page letters that described the project and identified and demonstrated adherence to required documentation for each eligible applicant (e.g. 501c3 status. letters of commitment from partners, etc.). Organizations that provided a Letter Of Intent would be eligible to apply for the grant if they met these minimum set of standards. This two step process also helped to define the group of providers that would be eligible in the final round.

On the deadline of the grant application, seventeen of the original Letter Of Intent respondents submitted a final grant application. Of the seventeen applications, there were at least ten compelling applications and six very strong entries, twice the amount that we intended to fund. A panel of three reviewers evaluated the grantees on a 600 point scale, seeking to identify, specificity in program design, clear utilization of ILHIE Direct and a replicable and scalable design. We awarded six grantees for the following projects.

Table 1: BHIP Demonstration Pro·ect Grantees, Se tember 2012

Geography		Type of Provider	Project Descri tion		
Central Illinois: Springfield	Mental Health Centers of Central Illinois	MH/SA	Mental Health Triage in Emergency Department	$	45,100
Central Illinois: Peoria	Human Service Center	MH/SA	Transitions of Care from Inpatient to Outpatient for Individuals with Mental Health Diagnoses	$	45,00C
Downstate: Carbondale & Carterville	The H Group	MH/DD/SA	Mental Health Triage in Emergency Department	$	44,300
Suburban Chicago: DuPage County	DuPage County Health Dept.	MH/SA	Coordinating Medical Care for the Severely Mental Ill Receiving Outpatient Services	$	39,600
Chicago	New Age Services	SA	Medical Exam and Physicals for Individuals in Methadone Treatment	$	45,000
Metro Chicago	Lutheran Social Services of Illinois	MH/SA	Youth in Mental Health Crisis -Inpatient and Outpatient Services	$	45,000
				$	264,000

The lifespan of the grant ran from September 17 through December 14 (approximately 12 weeks) and each grantee had to launch exchange with ILHIE Direct by October 8[1]h (week 3 of the grant). The majority of grantees accomplished this initial milestone. All grantees that completed this pilot phase spent an intentional period of time reengineering care and staff work processes to ensure that as documentation moved to the electronic sphere protocols were in place to manage sensitive information and adapted to faster administration of care by case. A couple of grantees had to stop the project and re-start in order to iron-out the work flow with their trading partners or with internal staff.

In the months of October and November, SHIP Demonstration Project grantees became super-users of ILHIE Direct, representing over 60% of message exchanges of all registrants of Direct at that time. This was a great discovery about the success of the demonstration projects: behavioral health providers that have selected a specific service to benefit from electronic exchange could adapt to electronic exchange quickly and realize remarkable efficiencies within the course of a twelve week demonstration project. This taught us not only about the capacity of behavioral health providers but also about the process of adapting to electronic exchange. From this finding. we developed an HIE Readiness Assessment for Behavioral Health providers to be rolled out during 2013.

Of the six grantees. five emerged as promising use cases. meaning that these five grantees would continue to implement utilizing ILHIE Direct and are seeking to make the process sustainable in the selectedcare environment. At least two of the grantees are attempting to take the process to scale with other trading partners. By virtue of introducing ILHIE Direct. where faxes and US Mail had be used, each of the use cases achieved remarkable efficiencies. largely in terms of time as well as in facilitating "a warm hand off' in the transition of care, greatly improving the potential for treatment compliance.

Table 2 BHIP Promising Use Cases, January 2013

Geography	Lead Provider	Provider	Use Case	Efficiency Gained
Central Illinois: Springfield	Mental Health Centers of Central Illinois	MH/SA	Mental Health Triage in Emergency Department	18 min/case: -667 hrs/yr for 2000 cases (This grantee is now expanding the process to an addition two hospital partners.)
Central Illinois: Peoria	Human Service Center	MH/SA	Transitions of Care from Inpatient to Outpatient for Individuals with Mental Health Diagnoses	Increased capture rate
Suburban Chicago: DuPage County	DuPage County Health Dept.	MH/SA	Coordinating Medical Care for the Severely Mental Ill Receiving Outpatient Services	Seamless transition to mobile medical care
Chicago	New Age Services	SA	Medical Exam and Physicals for Individuals in Methadone Treatment	On average. reduced delivery of medical information from 7 days to 2 days: no longer need to drive documents back and forth, staff have more time with consumers
Metro Chicago	Lutheran Social Services of Illinois	MH/SA	Youth in Mental Health Crisis -Inpatient and Outpatient Services	Introduced mobile assessment process and reduced assessment time from a high of 3.5 hrs to 90 mins/case: 1251hrs/yr for -770cases/yr

Demonstration Projects: Tools for Exchange

In preparation for the demonstration grants, we developed a tool-kit for consent management to lend clarity to the issue of patient authorization in an electronic environment. We also developed a web-based transition of care form that could be used by a provider that only had a computer and an internet connection.

Tool-Kit for Consent Management
The tool-kit that we developed reflected both work at the national level, being led by the National Council and the realities of current state law in Illinois. The tool-kit sought to clarify the actual consent form and the process of soliciting consent from consumers for the purpose of sending information electronically.

Finally, the tool-kit also offered an overview of all three privacy and consent laws that can come into play for mental health and substance use treatment providers.

The contents of the tool-kit include:
- Template Consent Form
- Instructions for the Consent Form and a Provider Script for Implementation
- Notice of Privacy Practice
- Side by Side Comparison of Consent Laws (HIPAA, 42CFR Part 2 and Illinois Law)

BHIP Prototype

IT team at OHIT researched and developed a transition of care document, known as the BHIP prototype, to facilitate the exchange of a clinical record that included behavioral health elements to support care coordination among participating behavioral health providers and their medical partners.

The IT team conducted a survey of all twenty-three respondents to the Request for Letters of Intent to identify the capacity of respondents in terms of electronic medical record systems, generating client reports and using data to inform services. Nearly 87% (20) of respondents participated in the survey. We learned that:
- 85% had EHR systems
- Of 17 respondents, 12 had a CCHIT certified system and 16 could support specific transitions of care documentation; 10 had had the system for 5 or more years
- A majority of respondents ranked HL7 and the CCD as the most important national standards to which they must adhere, followed by SNOMED and LOINC

The IT team developed the BHIP Prototype as a webform that converted into a pdf and could be used for encapsulating information related to four documents and related common elements: a discharge summary, consultation summary and

The Prototype was developed for implementation by grantees. While each of the six grantees introduced the webform, they found that existing forms addressed the reporting needs of the project. Consequently, webform was not adopted by grantees. The webform does, however, inform what fields will be of importance as the ILHIE develops query-based services that involve behavioral health providers.

Program Findings & Results

A profile of Illinois Medicaid recipients illustrates that 1 out of every 3 adults has a mental health or substance use disorder; and 1 out of 5 adults experiences co-morbidity of a chronic medical condition and behavioral health disorder. The complexity of recipient health conditions is not lost on providers or on consumers.

Over the course of implementing BHIP, we have compiled a complex understanding of providers and consumers involved in the behavioral healthcare system. We connected with over 384 unduplicated behavioral health organizations throughout Illinois and registered 81unduplicated behavioral health organizations and 352 staff members on ILHIE Direct.

We learned that behavioral health providers utilize and require patient health information, especially medical data, to inform the delivery of services. Many of these providers have adopted electronic medical

records systems, despite not having benefitted from Medicaid and Medicare incentive payments. Providers can actively adapt and accommodate electronic exchange through the adoption of ILHIE Direct. What is emerging in Illinois is a sophisticated provider base that is actively seeking ways to incorporate medical services and information into the existing behavioral service platform to address the needs of a client populations coping with disorders, dual diagnosis and co-morbidity.

We have also learned that clients prioritize access to healthcare. Substance use treatment consumers especially voiced concerns regarding drug interactions or resistance to general anesthesia. Since consumers indicated that they rely on their existing providers to facilitate referrals to medical providers, they felt that they could trust physicians involved in their treatment. And it was in the consumer focus groups that we learned that substance use treatment consumers appear to have a great deal of curiosity in relation to how physicians can track and coordinate information regarding prescriptions.

When conversations turned towards privacy rights, consumers largely wanted to know what their rights are and where they could find information regarding their rights. Younger consumers stated that they would like to see a website carrying all of this information. Most consumers acknowledged that consent is handled in such a way that they do not even know what they are signing most of the time. What reassures them is that they trust their providers, an implication that suggests that they don't need specifics on the consent process.

Providers also indicated that they have a role in consent. When asked who and how should patient authorization be solicited, providers most frequently indicated that consent was an essential feature of treatment and should remain the province of providers to manage and implement.

When it comes to the actual exchange of patient information in an electronic environment, we learned that implementing ILHIE Direct, a secured, encrypted messaging service, is not a plug and play opportunity. Rather, for both beneficiaries and the services to benefit from electronic exchange, there has to be an intentional change management process that identifies specific process change among all trading parties.

Further, we found that behavioral health providers are super-users of ILHIE Direct. And, these providers are pushing the envelope looking at new ways to improve the technological platform to improve services. For example, behavioral health providers have expressed interest in Enterprise Direct. a service that will imbed ILHIE Direct into an EMR system. Behavioral health providers are also interested in reviewing and testing the behavioral health CCD, recently released from HL7 in draft form.

The Second Statewide Meeting, held on November 1, 2012 provided the opportunity to share these findings with stakeholders throughout the state. Two hundred and forty five individuals attended the meeting and approximately 176 or 72% represented behavioral health and medical providers. The central location for the meeting was in Naperville, with a video-conference site in Springfield and webinar capabilities.

On February 14, 2013, OHIT held a webinar to share the findings and accomplishments of BHIP. Over 200 individuals registered and over 180 participated in the webinar. As the presentation shifted to the question and answer segment, we were greeted by congratulatory comments from participants for a job well done. The enthusiasm that has carried this project in large part reflects the interest and desire of behavioral health providers and consumers seeking new ways of solving an old problem, the problem of

access to care when it is needed. By demonstrating that behavioral health providers can exchange patient health data electronically, supporting a "warm hand-off" to relevant services in a minimal amount of time, we have shown that solutions to this old problem do exist.

Still More to Do

BHIP provided an excellent foundation to engaging and connecting behavioral health providers and consumers to the development of the ILHIE. Legacy planning for BHIP has turned to continuing the most promising aspects of the project.

Perhaps most important on the list of next steps is the legislation to modernize the state mental health confidentiality act. We have introduced the legislation with eight endorsing entities:
- Community Behavioral Healthcare Association of Illinois
- Illinois Alcoholism and Drug Dependence Association
- Illinois Association of Rehabilitation Facilities
- Illinois Hospital Association
- Illinois Psychiatric Society
- Illinois Primary Health Care Association
- Illinois State Medical Society
- National Association of Social Workers – Illinois Chapter

We are also in the process of pushing out the promising use cases that have been identified through the development of BHIP demonstration projects. In the months of February and March 2013, we are holding webinars to highlight the findings of BHIP and showcase the use cases to illustrate how each provider selected the services to convert to electronic exchange, utilizing ILHIE Direct. These webinars also seek to promote the use of ILHIE Direct by behavioral health providers.

To promote the tools that behavioral health providers will need as they become more proficient in coordinated care environments, involving multiple trading partner and electronic exchange, we have partners with one of the trade associations to build out a resource webpage containing this information.

Finally, we are also in the process of connecting a small handful of providers to testing more sophisticated HIT, such as the Enterprise Direct and the behavioral health CCD.

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Appendices

BHIP Web Page: http://www2.illinois.gov/gov/HIE/Pages/BHIP.aspx
ILHIE Web Site: hie.illinois.gov